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DATE NOTICE SENT TO ALL PARTIES: Jan/07/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right sacroiliac joint injection with fluoroscopy and anesthesia

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD Board Certified Anesthesiology

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is XX/XX/XX. The patient sustained a lifting injury at work. The patient underwent lumbar medial branch blocks on XX/XX/XX. Note dated XX/XX/XX indicates that the patient underwent lumbar medial branch blocks with no improvement in pain noted. Office visit note dated XX/XX/XX indicates that deep tendon reflexes are diminished and straight leg raising is positive on the right. Behavioral evaluation dated X/XX/XX indicates that the patient completed 9-10 sessions of physical therapy and his pain has continued with no relief. MRI of the lumbar spine dated XX/XX/XX revealed right sided sacralization of L5, multilevel facet arthropathy, mild right foraminal narrowing and moderate left foraminal narrowing at L4-5; disc space narrowing, disc desiccation and mild left foraminal narrowing at L5-S1; no significant spinal stenosis. Office visit note dated XX/XX/XX indicates that on physical examination heel and toe walking are good. Deep tendon reflexes are intact in the lower extremities. Straight leg raising is negative bilaterally. Patrick's sign is positive on the right. Office visit note dated XX/XX/XX indicates that the patient complains of low back pain. Pain level is 0-3/10. The patient was approved for work conditioning, but he does not wish to do it at this time; he wants to see if he can get an injection. There are no significant changes on physical examination. Diagnoses are lumbosacral sprain and lumbar strain.

Initial request for right sacroiliac joint injection with fluoroscopy and anesthesia was non-certified on XX/XX/XX noting that the request is not supported by the Official Disability Guidelines Hip and Pelvis Chapter, sacroiliac injections. Per the guidelines, diagnostic sacroiliac joint injections are not recommended. Therapeutic sacroiliac joint injections are not recommended. The provider did confirm this patient does not have a diagnosis of any form of inflammatory spondyloarthropathy based upon his available information. The denial was upheld on appeal dated XX/XX/XX noting that the request is not supported by the Official Disability Guidelines.
There is no indication why the patient would be considered to be an outlier to the guidelines. In this case, there is no documentation showing why this procedure should be performed. There is also no documentation showing a long term treatment plan or why sedation was requested for the procedure.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on XX/XX/XX as a result of lifting at work. Treatment to date has included physical therapy and lumbar medial branch blocks. The patient has been recommended for sacroiliac joint injection. However, the Official Disability Guidelines no longer support the performance of this procedure. There is no clear rationale provided to support the performance of a sacroiliac joint injection as an outlier to the Official Disability Guidelines. The patient's most recent physical examination documents only positive Patrick's sign on the right. As such, it is the opinion of the reviewer that the request for right sacroiliac joint injection with fluoroscopy and anesthesia is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)